Date Received (stamp):

DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
(617) 973-0865
http://www.mass.gov/dph/boards/

Entered into the Database(Date): _____/ _____/ _____ **Docket #:_____-_____-_____**

Acknowledgement letter sent (Date): _____/ _____/ _____ **Signature: _____**

Please complete this form as fully as possible. **(PLEASE DO NOT WRITE ABOVE LINE.)** Please type or print legibly in ink

COMPLAINT BY:

Name: _____ _____ _____
Last Name First Name M.I.

Business Name: _____
(if applicable)

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code Evening Phone

Best way to reach you: □Evening Phone □Daytime Phone □E-mail:_____

COMPLAINT AGAINST (use separate form for each licensed individual):

Name: _____ _____ _____
Last Name First Name M.I.

Address: _____ _____
Number Street Daytime Phone

_____ _____ _____ _____
City State Zip Code License Number/Type Class

_____
Business Name

_____ _____
Business Address Daytime Phone

_____ _____ _____ _____
City State Zip Code Business License # / Type Class

Please check the trade or profession that this complaint pertains to:

Dental

_____ Dentist

_____ Dental Hygienists

Nursing

_____ Licensed Practical Nurse

_____ Registered Nurse

Pharmacy

_____ Pharmacist

_____ Pharmacy Technician

_____ Drug Store

_____ Warehouse Distributor

_____ Nursing Home Administrator **_____ Physicians Assistant**

_____ Perfusionist **_____ Respiratory Care Therapist**

Description of the Complaint:

Briefly describe the incidents that led to your complaint and note the times and dates that events occurred. List the names of all individuals involved. Please attach additional pages if needed.

(Please use a separate sheet if necessary. Please do not write in the margins.)

Additional information or materials attached ☐Yes ☐No

To speed up processing your complaint, please submit legible copies (not the originals) of all relative documents supporting your complaint (i.e. contracts, medical records, cancelled checks, etc.). You will receive an acknowledgement letter with the name of the investigator assigned to your case.

AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature to this form, or a photocopy thereof, authorizes the Department of Public Health to:
(1) receive copies of all medical, dental and mental health records relating to my complaint, and (2) to refer my complaint to other appropriate law enforcement authorities to investigate and/or prosecute my complaint.

Please note that all complaints are investigated to determine their factual basis. The act of filing a complaint does not assure or imply that disciplinary action will be taken against the licensee.

I attest that the information provided is true, correct and complete to the best of my knowledge.

Complainant signature Date

Mail this form to:

Department of Public Health
Division of Health Professions Licensure
239 Causeway Street ~ 2nd Fl., Suite 200
Boston, MA 02114